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ABSTRACT

This two-day conference heard from leaders on national trends in health manpower, with particular emphasis on the granting of equivalency credit for relevant experience. Presentations were made under these areas: opening doors to health careers, national trends in allied health testing, innovative approaches to allied health equivalency testing in Maryland, and the allied health professional and health care delivery. Participants were then divided into task forces to address the more specific facets of equivalency testing; questions such as the role of licensing boards, professional associations, military experience, test design, and legal problems. The seminar was closed with the conclusions and recommendations of each task force. (RC)

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PREFACE

This publication presents materials included in a report made to the Division of Allied Health Manpower, Bureau of Health Manpower Education, National Institutes of Health, as a part of NIH Contract 71-4165.

The Maryland Hospital Education and Research Foundation was the contractor for the seminar on Equivalency Testing for Allied Health Personnel which was held at the Hunt Valley Inn, Cockeysville, Maryland, on October 19 and 20, 1971. The proceedings are published in this format to provide a record of the seminar for the participants, with limited distribution to others who will be interested in the occasion which brought together health professionals and educators to focus attention on equivalency testing within the State. The presentations made at the meeting and the recommendations developed at the work sessions are included as they were submitted at the time of the seminar, with minimal editing.

EQUIVALENCY TESTING FOR ALLIED HEALTH MANPOWER IN MARYLAND

Seminar,
October 19-20, 1971

NIH Contract 71-4165

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INTRODUCTION

John F. Bacon

This country's health manpower, as it has emerged in the service of health care delivery and maintenance, falls far short of serving optimal needs. Indeed, as our society increases its insights into the complex factors that constitute community health, our present manpower utilization calls for most careful scrutiny and change.

Here and there throughout the country, we identify starts in the reexamination of existing health manpower. Methods of utilization are evolving for the betterment of the system of health care delivery and maintenance, and for the individuals providing and receiving that care, as well. The myriad, related questions for health workers include such factors as relevant licensure and certification, realistic educational requirements, and perceptive competencies for job performance.

It is in the interests of a coordinated approach toward working on some of these factors, that the Maryland Hospital Education and Research Foundation has invited representation from approximately one hundred health and education institutions in Maryland. This two-day conference on Equivalency Testing for Allied Health Manpower will hear from leaders outside of Maryland, on national trends in health manpower, with particular emphasis on the granting of equivalency credit for relevant experience. We will then be briefed by leaders within the State on innovative approaches in the planning or operational stage within their institutions. Finally, we will divide into task forces, addressing ourselves to more specific facets of equivalency testing; questions such as the role of licensing boards, professional associations, military experience and so forth. We will then reconvene and close our two-day conference with the conclusions and recommendations of each task force.

The matter of clarity in the usage of such terms as equivalency testing, certification, and credentialing becomes confusing at times and, in the interest of standardizing terminology, we include in these materials a glossary prepared by the Division of Allied Health Manpower, National Institutes of Health.

GREETINGS

Sherburne B. Walker

I bring the warmest greetings of the Maryland Hospital Association's Board of Presidents. We have followed the planning of this important meeting with close interest since we first learned that it would take place.

Today you will be addressing yourselves to a subject that, if not entirely neglected in the past, has certainly not attracted the attention and commitment that it deserves from all members of the health care community.

We are a community that faces a full-fledged manpower crisis. While there are 3,500,000 men and women working in health care today, experts forecast an almost immediate need for 283,000 more.

Some of today's more than 4 million unemployed Americans must be attracted to fill our needs. And we must also draw youth into this greatest of U.S. growth industries. But in undertaking these appeals, we are both obliged and offered encouragement by the opportunity before us to find many of the people we need right within our present family.

Equivalency testing may in fact and in other words be the key to filling the greatest needs of our industry today.

You will be exploring how such a procedure can work to our advantage. And, even aside from the manpower-usefulness aspects of equivalency testing, I need not remind you that, in dealing with it, you will be touching some of the most critical social problems facing the country and Maryland at this time.

It will require two days of your most careful attention and thought. Please volunteer both.

The Maryland Hospital Association awaits a report on your activities here with genuine hope that you will provide a lead to the entire field in finding a determined means to advance many of the health care workers that are already among us.

Please work hard and make this a fruitful meeting.

OPENING DOORS TO HEALTH CAREERS

Keynote Address

J. Warren Perry, Ph.D.
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OPENING DOORS TO HEALTH CAREERS

J. Warren Perry, Ph.D.

In Chicago at the 65th Annual Congress on Medical Education, sponsored by the AMA Council on Medical Education in 1968, I had the privilege of delivering one of the first speeches on career mobility in the health professions. One of the factors I identified at that time for implementing career mobility was the development of equivalency tests that would provide the possibility of equating knowledge and experience with prescribed levels of formal education. Little did I dream that within less than four years I would be speaking at a seminar that had as its major objective the discussion of the status of equivalency testing for allied health education. Our professional experiences have a way of repeating themselves, and nothing can be more satisfying than to see one of your early aspirations being translated into an action program. I salute those of you in Maryland, both the Hospital Education and Research Foundation and the National Institutes of Health division that makes this possible.

This speech will be divided into two sections: (1) the trends in allied health that will continue to require major manpower expansion in all fields, and (2) the importance of equivalency testing as one of the primary elements in attracting and maintaining sufficient manpower in health related professions and occupations.

I. Trends in Allied Health

A. Expansion of Allied Health Educational Programs

The creation of new educational structures at all levels as new divisions, schools and colleges for the allied health professions have become one of the most far-reaching innovations in health education in several decades.

Training programs in the United States have been identified for over 130 allied health fields. Today about 900 colleges and universities are involved in the education of allied health personnel at the baccalaureate degree or higher. At the same time, over three-fourths of the existing community-junior colleges, and over 1,000 are in functional operation, have already developed allied health programs, and at recent count at least 119 others are in the process of implementation. These new curricula at the Associate degree level embody some of the most exciting educational innovations in operation today. Literally every hospital in the United States is involved in one way or another in the training of allied health workers at one level or another. There is the potential for development of allied health manpower at all levels scarcely dreamed of several years ago.

B. Utilization of Allied Health Personnel

There is a theory, which many of us support, that health care in this country will never be a workable system until all of the health professions are recognized for what each can contribute. Priority attention must be given to educational and clinical programs at all levels for the allied health professions and occupations, but until the capabilities and responsibilities of each allied health role is understood, appreciated and utilized by the medical and dental community, we will never have a system or systems of health care. This level of utilization must not be assumed as forthcoming--it must be taught as an integral part of the medical and dental school curricula. We talk a good line about the mythical "team" of health workers, but there are few evidences of demonstrations of health profession teams in clinical service programs in action.

C. Need for Additional Clinical Centers for Training

A required segment of allied health education is clinical practice in a health facility. One of the major constraints to the orderly development of the allied health educational programs has been the tremendous need for clinical sites for these programs--many more sites than are available today. This need is equally critical for both community college and university programs, and because of the paucity of clinical space, many programs are stymied in the numbers of students that can be admitted.

D. Allied Health's Role in Expansion of New Clinical Centers

The expansion of health care services into many new clinical programs will assure new and expanding roles for the allied health professions. Neighborhood health care centers, nursing home and extended care facilities, rehabilitation institutes, inner-city health projects, and rural health manpower resources--these new programs which are attempting to respond to important health needs of society, will seldom reach fruition without the availability of allied health manpower in quantity and quality to staff them. Graduates from all levels of programs (certificate, associate, baccalaureate and advanced degrees) will find unlimited opportunities for clinical service in these new health delivery settings. There will never be enough medical or nursing personnel to staff these facilities, thus representatives of allied health fields must be prepared to assume significant roles in these new facilities.

E. Allied Health's Relationship to the Health Maintenance Concept

If the comprehensive spectrum of health maintenance (beginning with environmental and prevention activities, through intensive and acute care, and progressing to extended care and rehabilitation services) is ever to become a realistic goal as a response to society's total health needs, then all of the health professions must be delegated important roles in implementation of new health maintenance organizations. Although HMO's must be considered as only one specific response to a new geographic delivery system, it has been disappointing to see that some proposals for implementation of this new concept have been little more than medical group practice for a specified clientele. Attention to environmental, prevention, and extended care emphases are almost entirely missing in the few proposed plans for HMO's that I have seen. That is why we are holding a 2½ day institute in Buffalo this week, Health Maintenance - Challenge to the Allied Health Professions, funded by the Division of Allied Health Manpower, Bureau of Health Manpower Education. This institute will bring to Buffalo 15 representatives from each of nine allied health fields.

The challenge is to delineate the clinical role of allied health in health maintenance, as well as the educational changes necessary to embrace this stated emphasis of the 1972 health program. Task oriented as this Institute is, it will be a tremendous challenge for each field to assess its strengths, limitations, and potentials for service under the banner of the health maintenance concept. Time does not permit discussion of all trends, but we must conclude that educational institutions and professions are actively discussing career mobility and specifically the articulation between educational programs at all levels.

II. The Importance of Equivalency Testing

Let's begin with definition, for on too many occasions I have heard the terms "equivalency" and "proficiency" used interchangeably. Although

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these two forms of testing compliment each other very well, we must recognize the essential differences. "Proficiency testing assesses an individual's knowledge and skills related to the actual demands of an occupational speciality or a specific job."* "Equivalency testing equates learning gained outside of formal training programs with the requirements of courses that constitute recognized formal training programs."*

The recent efforts of measurement of equivalency were not the first attempts to measure capabilities by other than classroom attendance. Developed following World War II, the GED (General Educational Development) tests were established by the American Council on Education as a means to assist veterans in obtaining high school diplomas without attendance in high school classes. These tests opened up the doors of college admissions to thousands of qualified veterans, and they remain today as the most widely used equivalency test for the five areas of high school level English, social studies, natural sciences, literature, and mathematics. These tests have been in use for almost twenty years, and I recall using them in counseling students in the Chicago VA Guidance Center as early as 1951.

In my own State of New York, the College Proficiency Examination Program (CPEP) has been in operation since 1962. This is a most significant effort to open up the educational programs of the State to individuals who have acquired college-level knowledge in ways other than through regular classroom attendance.

Examinations of this kind are set up to recognize that other avenues of learning are available other than classroom experience. Some of these deserve mention here: adult education courses, independent and self-study, television courses, correspondence courses, programmed learning experiences, or other non-degree kinds of courses, and on-the-job experience. These deserve transferability into college credit, and CPEP, among others of this nature, are making this level of achievement possible to students of all ages.

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*Equivalency and Proficiency Testing: A Survey of Existing Testing Programs in Allied Health and Other Health Fields. Unnumbered NIH publication. U.S. Department of Health, Education, and Welfare; National Institutes of Health. Washington, Government Printing Office, 1971.

With the increasing attention being given to the need for increasing health manpower, it is consistent with this need that attention is now being riveted on the importance of equivalency testing for the health fields. A brief look at what has already been done deserves special attention. Testing programs in the medical laboratory field have led all others in these specialized testing programs. As early as 1967, the National Committee for Careers in Medical Technology obtained a grant from the Division of Allied Health Manpower to hold a conference to research the field and develop appropriate tests for equivalency purposes. This field has set the pattern that all others must now follow. Nursing and physical therapy have also been pioneers in attempts to delineate the efficacy of equivalency testing for each field, and today few of the allied health fields have not established committees that are delving further into the importance of equivalency testing for its own purposes.

I would like to summarize what I consider to be some of the guiding principles in relation to equivalency testing. These are tentative in nature, due to the lack of experience with these new forms and the relatively short period of time devoted to the state of the art in equivalency testing.

1. In our efforts to attract and retain allied health manpower,

vertical and horizontal mobility between and among these fields will depend in large measure on a well-conceived system of equivalency testing yet to be developed for each allied health profession and occupation.

2. There needs to be developed a national public relations program on the availability of equivalency testing in relation to college credit for all kinds of formerly non-credit types of activities: adult education, self-instruction, television, etc. Too many persons do not understand or appreciate the availability of testing that can measure the effectiveness of non-class activities.

3. Equivalency testing should not be considered as a means of short-circuiting or lowering of requirements for academic preparation. Rather equivalency testing should be considered as *an alternate route to achieve the same objective*, for the end result must be consistent with the maintenance of effective standards of professional service.

4. Personnel in academic institutions, including admissions officers, faculty of professional health curricula, and administrative staff must be willing to understand and accept the results of equivalency testing. Though each institution will accept responsibility for the amount of credit it will apply toward academic requirements, there has to be instilled within all persons involved in decision-making positions the willingness to change admission policies and credit procedures to comply with equivalency credit.

5. Evaluation of the results of these first attempts at equivalency testing for the allied health professions must be rigorously pursued. Each allied health field should develop reliable evaluative measures, for these studies will point the way to future utilization of equivalency procedures.

6. The concept of equivalency testing is so important for all of the allied health professions that there must continue to be active cooperation, effective communication and close coordination among all representatives of each profession who are devoting time and energies to the development of testing procedures. This coordination among professionals would include university and community college centers, the Armed Forces, and our professional testing experts.

I am going to close with a quotation that some of you here have heard me use in my speeches before. Time and again I return to it. Perhaps the challenge with which we are faced can be summed up by quoting from the writings of that most quotable young man, the late President Kennedy, who said:

> "Of those to whom much is given, much is required. And when at some future date the high court of history sits in judgment on each of us, recording whether in our brief span of service we fulfilled our responsibilities, we will be measured by the answers to four questions: Were we truly men of courage? Were we truly men of judgment? Were we truly men of integrity? And were we truly men of dedication? Mankind waits upon our answer; and many look to see what we will do. We cannot fail their trust. We cannot fail to try."

I submit that here in Maryland during the next few days you will be analyzing what has already been accomplished or what needs to be accomplished in equivalency testing. Share with all of us your results, for we can profit by your discussions and your decisions. Hopefully, you will be pointing the directions that we in the allied health professions must still achieve together.

NATIONAL TRENDS IN EQUIVALENCY TESTING

James E. Griffin, Ph.D.
Chairman and Professor
Department of Physical Therapy
School of Health Related Professions
State University of New York at Buffalo

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NATIONAL TRENDS IN EQUIVALENCY TESTING

James E. Griffin, Ph.D.

I am talking to you this morning by virtue of the fact that I am Chairman of the Committee on Equivalency and Proficiency Testing of the Association of Schools of Allied Health Professions, and a Department Chairman in an allied health profession in the State of New York, which has a larger real commitment to allied health careers than any other state in the Union.

The concept of credit by examination started to receive national attention in the late 1950's. For many reasons this has been more feasible in the areas of social sciences and humanities as compared to the biological and physical sciences, but as shortages in allied health personnel have continued to worsen in spite of various recruitment approaches, and possibly as more men have expressed interest in entering these fields, more pressure has accrued for modification of rigid lock-step curricula leading to dead-end employment, with sometimes substantial waste of training time.

The first allied health group to do something about these pressures, rather than just talk about them, were the organizations representing various levels of medical technology training. The groups have in operation on a nationwide basis a proficiency testing program which permits discharged service personnel who have had laboratory training as medical corpsmen to take examinations which would qualify them for civilian employment as clinical laboratory personnel at the technician level. The examination is offered in four subject matter areas, having been developed by Educational Testing Service under contract with the Department of Labor. In the same four subjects, equivalency examinations are being developed by ETS under contract with the Division of Allied Health Manpower. They are to be open to ex-servicemen and others with experience and knowledge gained outside of the usual approach to qualify them for advanced placement in the academic world. Passing of equivalency tests could excuse them from classroom and practical work that they need not repeat while working towards an associate degree.

The Department of Education in the State of New York has pushed for a similar program of equivalency testing for credit by examination in the field of nursing. The testing program has been in use for nearly five years and has been administered to over 5,000 individuals who started their careers as nursing aides or licensed practical nurses and who wished to further their training without having to repeat certain academic or practical components of training. This program likewise was carefully developed and is acceptable to many of the senior nursing schools. A number of other states are following New York's lead.

I wish I could say that other allied health professions have been as effective in developing career mobility programs for their fields, but they have not. All give very nice sounding lip service to the concept but so far have produced only task forces or other committees to tackle the problems involved. A real stumbling block has been the cost of developing a valid credit by examination system. It has cost more than a quarter of a million dollars to do so to date in the area of medical technology for equivalency testing alone. The program for proficiency testing will also be expensive. In this particular case development was financed through a grant from the Bureau of Allied Health Manpower.

Remembering that what I say from here on is personal opinion, rather than documentable evidence, I think another major stumbling block for such programs is fear! Fear on the part of various baccalaureate program directors and faculty that if they encourage credit by examination, it will soon be apparent that many so-called baccalaureate programs are not producing as clinically useful a product as the programs which have required far less training in terms of clock hours.

This is in part due to the fact that changes in some program curricula have not kept up with changes in clinical management of patients. This is particularly apt to be the case when the instructors have retired from clinical work and have not kept up via their own program for continuing education.

This is in part due to the fact that many programs in the allied health fields do all they can to discourage research into patient problems in any way, shape or form, usually by stating or otherwise demonstrating they feel that research is beyond their ken, or that other demands on their time are too great. These are sometimes valid reasons for not participating in or at least not keeping up with investigative reports, but I suspect that the lack of such participation is more usually due to the fact that the supposed leaders have gotten into a nice, comfortable rut where they no longer have to think but can respond by rote, and as long as they mind their budgetary P's and Q's nobody asks any embarrassing questions.

This may be in part due to the fact that many clinicians don't want to see their job roles change. As a specific example, I recently chaired a two-day conference titled, "Patient Evaluation - Let's Talk About It." Physical therapy schools for more than a quarter of a century have been preaching and teaching the merits of formal objective patient evaluation before and after treatment. Clinics have largely ignored the procedure with the usual excuse: our patient load is too great; yet recently the National Council of Physical Therapy School Directors resolved to increase time allotted for teaching theory and procedures in objective evaluation. At the aforementioned conference, formal presentations by nationally known speakers were given on the logic of testing, new aspects of testing, and tried-and-true objective tests. The reaction of the clinical reactor panel to the presentation was: forget it, we want to treat patients, not test them. Let others do the testing, if it is necessary at all.

In my opinion they don't want to get involved in formal testing because then they can no longer do things by rote, but would have to think and make judgments--and they might find their beloved treatment of not much benefit.

Whatever the reasons, baccalaureate programs which have been operational for a long time have done little or nothing to encourage credit by examination, and I suspect they will not do so as long as they can delay this concept as an educational tool to save everyone's time. They probably won't until they are nudged firmly by the national organization involved. National organizations with which I have been connected seem much more prone to talk rather than act, possibly because they are reluctant to bring about change even if only a small part of their membership would be hurt although the largest part would benefit.

I suspect the national organizations are going to have to be nudged by law and/or pressure of public opinion before they will embrace wholeheartedly the concept of upward mobility, including credit by examination as a major factor in career mobility.

THE ISSUES INVOLVED IN DEVELOPING EQUIVALENCY TESTING PROGRAMS FOR ALLIED HEALTH PROFESSIONALS

Israel Light, Ed.D.
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THE ISSUES INVOLVED IN DEVELOPING EQUIVALENCY TESTING PROGRAMS FOR ALLIED HEALTH PROFESSIONALS

Israel Light, Ed.D.

I am quite proud of the fact that I am one of the parents of Al Serling's current CLEP equivalency examination project in Medical Technology, because I recall visiting ETS and developing quite a flourishing correspondence and direct contact with Ben Shimberg, Barbara Esser, Campbell, and the rest of that group some five years ago. I am equally proud of my ex-colleagues but still good friends at NIH who persisted, pursued, and consummated the contract that was eventually arranged.

I will presume to say a few things on behalf of our full panel, so let me jump right in. We certainly must believe that people are more important than anybody. We certainly must believe that people are smarter than most educational systems give them credit for being. And we must agree people do, indeed, acquire vast amounts of knowledge, competence, and skill outside of traditional educational formats. I must confess, however, that anyone holding such beliefs is automatically labeled a maverick educator. Must educators really do hold these very reasonable beliefs but they remain pious declarations of intent, for the most part. Anyone who dares to implement these beliefs is just about considered guilty until he or she proves to be innocent.

As we all know, we suffer nationally from a severe case of "infectious credentialitis." Just get that piece of paper, never mind how. The credential is a prized status symbol of our times and culture. The prime, almost exclusive, way of securing the credential is to accumulate academic credits. This is easy. Both the moron and the genius can pick up academic credits. Competence has been equated with the credential, although anyone who has to meet a payroll knows that, especially in the lower half of any occupational hierarchy, this equation just isn't for real except in selected, individual cases.

Therefore, what has happened is that educators, the national professional societies, the regulatory mechanisms, and the employers have all agreed to equate job eligibility almost exclusively with educational achievement. So one needs the piece of paper more to get the job than to do the job. I'm convinced that this is one of the important reasons for the great job turnover and attrition rate to be found in the allied health field. The lack of occupational analysis or job or task analysis has kept the gap between Academia and the world of work so wide that, when a young person graduates, presumably appropriately prepared for his job, he suddenly finds that it is beneath his dignity, or he can do the job with one arm tied behind his back, or he is not using all the knowledge and skills he has acquired, or otherwise becomes quite disillusioned.

Okay, so get the academic credits, no matter what or how. Then, at least, you have credibility and legitimacy, if not competence. But we must consider the raw material. The total work force in the medical-health field is currently 3.5 to 4 million and expected to grow to more than 5 million by 1980, according to the Bureau of Health Manpower Education, NIH. As of now, about 8% are physicians, another 18% are active-duty nurses, and dentists add a few more percentage points. So we're talking about 70% of this total workforce, for whom the baccalaureate will be the Holy Grail and the pinnacle of their educational achievement.

I repeat--I submit that in the lower half of any occupational hierarchy, the credential does not equate with competence as often as it should. We need a more judicious "mix" of general and technical education at the secondary school and junior and senior college level. We're not getting it because what Academia says and what Academia does are very different things. I have absolutely no trouble at all in demolishing general education and the liberal arts as currently offered and taught. At best it is increasingly irrelevant, and at worst it is phony. Any attempt to suggest even a modest occupational orientation to baccalaureate education automatically brings howls of anguish from our more traditionally oriented educator colleagues. I'm convinced that undergraduate general education is in the hands of the very finest minds of the 12th Century. A few voices have been raised--Dean Ernest May of Harvard College and Dr. Robbin Fleming, President of the University of Michigan--questioning the relevance of a pre-scientific-age developed curriculum to modern life. But not too many people are listening. So we wind up with a sort of GNP, not Gross National Product, but a Gross Nonsense Product.

I will admit, however, that the very existence of CEEB-ETS is some kind of proof that the academic credit may not be all it should be. Agencies like these are trying to make Academia go more legitimate. Good! I just don't think they go far enough, neither Academia nor groups like CEEB-ETS. We must still distinguish between access and accommodation. I don't care how CUNY's experiment comes out, it is still a grand exercise in access, in fitting the individual to the System. It is high time that, if we really believe that people are more important than anybody, the System ought to adjust to the individual, if only to prove that it is possible, even though expensive. We'd better put some action where our mouth is, and this is what I mean by accommodation--adjusting the System to the individual.

Through the years a credit hour has come to mean a unit for expressing quantitatively the time required for mastery of a course. But, as we all know, there are courses and courses. And what is minimal mastery in one course in one institution may be much more than that in another institution. So we end up with the credit as representing clock hours.

The fact that we have nothing better at the moment than the academic credit as a standard is not a good enough reason to settle for it without persistent struggle to evolve more meaningful techniques and procedures for determining how much of what kind of knowledge and skill a person has acquired outside the Educational Establishment, and to make such credit negotiable currency.

As one publication describes the scene: "...course grades and the college degree have become such a mark of status in the job market that some students have sought to reduce the problem to a series of steps which may be taken in progression, restricting themselves to areas in which there are practical possibilities of success in amassing credits and marks which may do more to aid them in entering a vocation than in progressing in it."

We'd have to agree that most hospital administrators, for example, are not hiring people because they are "educated citizens" but because they are supposed to possess certain amounts and levels of technical skills required by the hospital. Not long ago, Harvard announced that if its LL.B. graduates filled out a form and sent in a check, they'd receive in return the Doctor of Laws degree credential in exchange.

There is another university in this country, for example, that will accept a high school graduate who has completed a two-year, hospital-based program in Radiologic Technology and who is a Registered RT, will give that student two years' college credit automatically, and after two years of college-level Lower Division studies, awards the B.S. in Radiologic Technology. I'd say that the B.S. does not stand for Bachelor of Science in this case, because, from an occupational and technical point of view, that graduate is *still* not one whit more technically competent than the day he left the hospital-based training program. So you see that we're playing phony, almost illegitimate educational and academic games.

Now, I say, let's not knock it. Along comes an agency with technical expertise that is ready, willing, and able to translate *knowledge*--not competence or skill yet, mind you--*knowledge* at the moment, and to try to evaluate and measure the knowledge acquired outside of traditional educational formats, and to translate such knowledge into an equivalence of what would be acquired in Academia. I think this is great. We must start somewhere. I'm pleased as Punch that the show is finally on the road. And the handwriting is on the wall, naturally, for all other health occupations, in addition to medical technology, to "Go ye do likewise."

But the proof of the suspicion of such moves by Academia is indicated by the persistent complaint that these exams are so very difficult and demanding as to suggest that anyone who passes one would be the equivalent of a super-duper, triple-A, Number One, academic genius in that particular course in Academia. In effect, Academia seems to say that *it* is the fount of all wisdom and if anyone dares to acquire the knowledge, competencies, and skills in elementary bacteriology outside of Academia, the applicant or candidate must pay a penalty for having dared to so learn elementary bacteriology, and must go through a ringer. I would also dare to ask if what such tests measure is really *knowledge* or is it *information*. I'd ask Academia the same question in terms of what the credential stands for.

I'd ask this question because information can be put in dead storage, and this is what altogether too many minds are, for that matter. But knowledge may be something else again. It can be a very usable commodity. This is another way of suggesting that in the working world the proof of the pudding is still in showing what one can do with what one knows. So how come that most, if not all, tests are still confined to paper-and-pencil techniques? Nor do I consider it an advance to go from laborious individual test marking to self-marking sheets or filling in vertical lines with black graphite smudges. This is not methodology, this is gimmickry. Forgive my cynicism.

There really is no incentive to develop methodologies and techniques for translating such factors as decision-making skills, problem-solving skills, and judgmental talents, and work experience into academic terms, because Academia does not wish it so. It never dawns upon a high school chemistry teacher, for example, to become momentarily a first-rate vocational counselor by noting that when she teaches about Na and Cl and balancing an equation, that there is a very respectable category of professional in town, by the name of sanitary engineer, who uses this very same equation as part of the chlorination procedure as a result of which the student can go home and draw a glass of potable drinking water from any faucet. And at the medical school level, the basic medical sciences are usually taught as if every student is in the race to wind up a Nobel laureate in Biochemistry or what have you.

Perhaps its because so many of us have grown up under the banner and slogan of "Education for Life" instead of "Education is Life." And young people are, indeed, saying to us old-timers that we had better make the parts fit--or else!

Equivalency testing must get onto measuring and evaluating competence and skill and the "doing" aspects of our lives, as well as knowledge. And I persist in saying this because too many of us will decide that what we're doing now is so great an advance that we'll sit back, continue to refine these elementary procedures, and wait for another decade to take the next steps. No one can afford to wait that long. I repeat--no one can afford to wait that long, and the sooner we get on to the further stages of testing the better.

The Supreme Court recently gave this conference a realistic shot in the arm that you ought to know about. The Supreme Court of the United States recently ruled, in Griggs versus Duke Power Company of North Carolina, "that any tests used must measure the person for the job and not the person in the abstract." The requirements of any kind of credential, from high school diploma on up, and intelligence and aptitude testing, were noted by the Court as discriminating against many black people and other minority groups because the tests did not measure, predict, or demonstrate the applicant's capacity to do the job for which application was made.

Let me conclude with something written by the well-known management specialist, Peter Drucker: "For the first time in American history, there is a threat that society will be split in two by a 'diploma curtain.' The 50 per cent of the population who have 'only' a high school education (or a junior college degree, which is rapidly taking the place of the high school diploma) will not be considered eligible for meaningful opportunities. And the 15 to 20 per cent or so who have not finished high school are in danger of being considered unemployable altogether. This is stupid in the extreme. There is no correlation between academic accomplishment and capacity to perform (except perhaps in academic pursuits). There is, in other words, little reason to believe that the 50 per cent with 'higher education' represent a significantly greater reservoir of ability, maturity, and integrity than the other 50 per cent...

"And it would be very intelligent if educational institutions set up soon an 'earned' degree to be awarded for performance rather than for sitting the required time on school benches. Such a degree would have to be considered the full equal of one acquired in the more traditional and easier way."

THE CLEP PROGRAM AND ALLIED HEALTH

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THE CLEP PROGRAM AND ALLIED HEALTH

Albert M. Serling

I would like to talk first of what I will not be talking about. I will not be talking about the job proficiency tests which were designed to help employers obtain an objective evaluation of the knowledge and skills of the medical laboratory specialist trained in the military. The proficiency project has two primary aims:

1. To overcome undue barriers to employment and promotion, and
2. To provide laboratory employees an opportunity for upward mobility on the career ladder.

For more information on the proficiency project, you could do best to talk with Mrs. Jean Linehan, of the National Committee on Careers in Medical Laboratory, who is here with us today. I should like to talk about Dylan Thomas, Gerard Manley Hopkins and Andrew Marvell, but "time's winged chariot is hurrying near, and yonder all before us lie deserts of vast eternity." The greening of those deserts is CLEP's aim. Access to relief for victims of credentialitis is CLEP's goal.

In the summer of 1970, the National Institutes of Health (NIH) contracted with the College-Level Examination Program (CLEP) to develop college course equivalency tests (subject examinations) in four core courses commonly included in medical technology degree programs. NIH supported this venture in recognition of three basic facts:

1. There is a critical shortage of certified medical technologists in the civilian manpower pool;
2. Medical laboratory training takes place in the military services;
3. Veterans who have received extensive medical laboratory training in the military are denied the certification that would enable them to

use their skills for the nation's as well as their own benefit;

4. This fact also holds true for individuals trained in civilian laboratories.

Even the best tests are insufficient by themselves to provide accreditation to men and women who, though they have the requisite skills and training, are denied access to positions for which they are qualified. CLEP provides the means whereby people can gain college credits for college-level learning gained outside the traditional classroom. CLEP, sponsored by the College Entrance Examination Board (CEEB) and administered by the Educational Testing Service (ETS), endorsed by the Commission on the Accreditation of Service Experience, the American Council on Education, the Federation of Regional Accrediting Commissions of Higher Education, supported by the Carnegie Corporation, and accepted as the basis for awarding credit by nearly 900 American colleges and universities, is the appropriate mechanism by which the present barriers can be surmounted.

CEEB and ETS were strongly encouraged to assist this effort by several of the major professional organizations in the field:

American Society of Clinical Pathologists
American Society of Medical Technologists
Association of Medical Technologists
Association of Schools of Allied Health Professions
National Committee for Careers in the Medical Laboratory

Specifically, CEEB and ETS were asked to develop CLEP Subject Examinations in Clinical Chemistry, Hematology, Immunohematology, and Microbiology. The plan is to standardize these four new Subject Examinations at the conclusion of the 1971-72 academic year, so they will be available in Autumn, 1972. They will follow the model of the

29 CLEP Subject Examinations* in many academic fields now available and accepted by American collegiate institutions as a basis for awarding college credit. The availability of these new tests through a program built to close the gap between achievement and recognition will offer a new route for accrediting the uncredentialled but not unqualified Medical Technologist. To understand better these new medical technology tests, we need to know more about what CLEP is and how it works.

Just what is CLEP all about, anyway?

Established by CEEB in 1965 to provide a means of measuring the academic achievement of people outside the mainstream of college education, the Program services those who have acquired their education outside the classroom, or in nonaccredited institutions, or through non-credit college courses, or sometimes in traditional college-level courses. This national system of credit by examination rests on several basic assumptions:

1. People can and do acquire learning at the college level in non-traditional ways.

2. Institutions of higher education must be concerned primarily with what an individual knows, not merely with the number of hours he

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*Subject examinations now available are:

American Government
American History
American Literature
Analysis and Interpretation of Literature
Biology
College Algebra
College Algebra-Trigonometry
Computers and Data Processing
Educational Psychology
Elementary Computer Programming-Fortran IV
English Composition
English Literature
General Chemistry
General Psychology
Geology
History of American Education
Human Growth and Development
Introduction to Business Mngmt.
Introductory Accounting
Introductory Business Law
Introductory Calculus
Introductory Economics
Introductory Marketing
Introductory Sociology
Money and Banking
Statistics
Tests and Measurements
Trigonometry
Western Civilization

has sat in class or the number of credits he has amassed.

3. Nontraditional learning can be measured and compared with the learning acquired by traditional students.

The primary goals of CLEP, derived from the above assumptions, are as follows:

1. To provide a national program of examinations that can be used to evaluate college-level education no matter how it was achieved.

2. To stimulate colleges and universities to become more aware of the need for and the possibility of credit by examination.

3. To allow colleges and universities to develop appropriate procedures for the placement, accreditation, and admission of transfer students.

4. To assist adults who wish to continue their education in order to meet licensing and certification requirements or to qualify for higher positions.

In keeping with the Program's purposes and goals, CLEP's tests are constructed to measure knowledge acquired through nontraditional means as well as through formal college study. They are not designed to reflect a particular curriculum or course of study but to measure the basic core elements that are common to appropriate courses of study at many different colleges and universities.

What kinds of tests does CLEP offer?

To meet different kinds of curricular organization and measurement needs at colleges and universities, CLEP offers two types of tests for assessing individual achievement: General Examinations and Subject Examinations.

The five General Examinations -- English Composition, Humanities, Mathematics, Natural Sciences, and Social Sciences-History -- can be administered as a battery or individually in any combination. They are designed to assist those institutions whose curriculum includes the general education requirement that is normally met by a student's taking a variety of courses in the core areas. The General Examinations measure the kinds of knowledge and understanding that might be expected of a student who had successfully fulfilled his general education requirements.

In contrast to the General Examinations, which are used to measure general educational background, the Subject Examinations (college course equivalency tests) are essentially end-of-course tests developed for widely taught undergraduate courses. They measure the mastery of information, ideas and skills that would be expected of a student who has successfully completed a college course in a particular subject. The nature of the examinations can be summarized as follows:

1. The examinations are not based on the curriculum of any particular institution.

2. Each Subject Examination derives its content from the elements of appropriate college courses with similar objectives.

3. Each Subject Examination measures the outcome of a specialized college course.

4. The examinations stress understanding, not merely retention, of facts; the ability to perceive relationships; and the grasp of basic principles and concepts in each discipline.

5. The examinations are constructed in such a way that an individual does not need to be able to answer all the questions on them to demonstrate competence.

6. Test questions cover a range of difficulty both in the depth

of understanding required and the skills and abilities measured.

Each of the Subject Examinations is a 90-minute objective test consisting of multiple-choice questions. Most of the examinations also include optional essay sections, which require 90 minutes. Essay questions differ from multiple-choice questions in that they require the candidate to summon information from his memory and organize it clearly, logically, and concisely. In this way, he can demonstrate not only what he knows but how well he can express himself in terms of a problem posed in a particular discipline. Thus, essay tests measure one's ability to organize, use, and synthesize disparate ideas according to the demands of the questions.

Answers to essay questions are kept on file, and a reproduction of them will be routinely sent to the institution that receives the candidate's scores. The essays are graded by the institution that receives them, not by the College Board. For more information on whether or not the candidate should take the optional essay section of a Subject Examination, how his essays will be graded, or what weight his essay grades will be given in the total examination score, he is urged to communicate with the institution that is to receive his test results.

CLEP scores and what they mean

Scores by themselves have no significance. They take on meaning only when measured against some standard or norm. The national norms for the General Examinations are based on the test scores earned by a representative sample of American college and university students at the end of their sophomore year. The norms for each Subject Examination are based on the scores earned by college students who took the examination at the end of a college course in the subject. CLEP also collects and publishes data showing how the scores earned by college students on the Subject Examinations relate to their final grades at the end of the comparable courses. This kind of information enables the candidate to determine whether his test performance, as signified by his scores, is most like that of an excellent, average, or unsuccessful college student.

CLEP's national norms show how college students at a wide variety of colleges throughout the country have performed on CLEP tests. There is great variety among American colleges and universities; therefore, many collegiate institutions prefer to grant credit on their own norms based on the performance of their own students. Each institution that grants credit by examination through CLEP determines the score levels it requires for credit. The program, therefore, advises each candidate to find out from the institution at which he hopes to gain credit, what standards it will use to evaluate his performance.

How is CLEP available?

As recognition of learning regardless of how it was attained is CLEP's theme, so access is CLEP's byword. The services that CLEP provides are governed by the principle that any individual deserves access to the program's offerings. Anyone may take any CLEP test. The tests are offered once each month in test centers located in colleges throughout the United States. Details about where and how to take the tests and what institutions participate in CLEP are available in the CLEP Bulletin of Information for Candidates. CLEP candidates register directly with the center at which they wish to be tested rather than being channeled through and assigned by a central office. The candidate's scores, along with information about their meaning, are reported directly to him and to anyone else he designates. An individual's scores are never reported to anyone whom the candidate has not specifically authorized to receive them.

Back to Medical Technology

In Autumn 1972, CLEP will offer Subject Examinations in Medical Technology. Anyone who believes he has learned the equivalent of one or more of the subjects covered by the examinations may register at a CLEP center and take whichever of the tests he feels prepared for. He may also elect to take any other CLEP General or Subject Examination in order to gain additional college credits and further shorten the time and expense he must devote to formal academic instruction. In short, through CLEP, the untraditionally educated individual may focus his energies and attention on new rather than redundant studies, gaining academic credit for all his learning whether gained in the college classroom or elsewhere.

How do the CLEP tests relate to the Job Proficiency examinations?

The CLEP Subject Examinations or College Course Equivalency tests discussed in this article should *not* be confused with the quite different *Job Proficiency* examinations developed and administered by Educational Testing Service under the sponsorship of the National Committee for Careers in the Medical Laboratory and the U.S. Department of Labor. The job related Proficiency project has two primary aims: 1. To overcome undue barriers to employment and promotion, and 2. To provide laboratory employees an opportunity for upward mobility on the career ladder. The Job Proficiency examinations are designed to help *employers* obtain an objective evaluation of the on-the-job knowledge and skills of the military trained medical laboratory specialists and the civilian laboratory worker.

CLEP, of course, is no panacea for all the ills of the nation. But sensibly applied it can improve the health of many. It may provide just enough hope to keep in the allied health field a well-trained veteran who, faced with the time and expense of years of college, some of it repeating work he has already mastered, would otherwise drop out, depriving the citizenry of his services and himself of a deserved opportunity. By reducing the total resources needed to move a student from the start to the end of his higher education, a collegiate institution will be able to educate appropriately a greater number of students and thereby increase the health services available to the nation. Finally, instructors would be freed from the onerous task of teaching people what they already know and, by increasing their attention to students and subjects not yet introduced, could generally find teaching a more satisfying profession. For starters, the results of appropriate placement and credit for all can be less bored and more eager students, increased health manpower and fuller utilization of our institutions of higher education. So who loses?

EQUIVALENCY AND THE AIR FORCE CAREERS

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EQUIVALENCY AND THE AIR FORCE HEALTH CAREERS

Mary A. Goddard

We in the Air Force have for many years looked at our contribution to national effectiveness in purely military terms. But today in this era of social change, the Armed Services play an important sociological role in the sphere of education and training. While we train airmen to perform tasks necessary to operate a modern Air Force, we are at the same time teaching skills that make these airmen more useful citizens when they return to civilian life. An analysis of the Dictionary of Occupational Titles (DOT) indicates that 90% of the Air Force Career Specialties have equivalent civilian skills.

At the School of Health Care Sciences, we are organized into six teaching departments: Nursing, Medicine, Dentistry, Biomedical Sciences, Veterinary Medicine and Health Services Administration.

These departments conduct a total of 53 courses ranging from Medical Fundamentals through to the newest course, the Physician Assistant. Some of our courses are accredited and/or lead to licensure or certification. For example, the Licensed Vocational Nurse Course is accredited by the Texas Board, as are the courses for X-ray Technician, the Operating Room Specialist, Laboratory Technician, and Dental Assistant. The Physician Assistant program has been set up to meet all existing standards and, more, a consortium agreement has been established with the University of Texas for sharing of faculty and facilities in this program--all with an eye to the day when licensing or certification requirements are set. We will be ready to qualify, without having to patch up.

We are working closely with Midwestern University co-located with us in Wichita Falls and, in some health related courses, we also share faculty and facilities. We expect to expand greatly in this area and ultimately have programs taught in consortium which lead to the award of an Associate or Bachelor's degree.

But what about the 45 or so other courses that we teach? Because they don't lead to licensure, must we conclude that they are dead-end?

Before that question can be answered, we have to take a look at the Air Force method of training--using an analysis of job tasks, a job or specialty description is first developed. The major elements of the job are discerned and a training standard then is developed which defines the skill and knowledge required for each of those elements. The skills and knowledges are set at three proficiency levels: 3 level - Apprentice, 5 level - Semi-skilled, 7 level - Fully qualified.

The mission of our school in the basic courses that we teach is to graduate an airman ready to perform at the 3 level. He advances to the 5 or 7 level, while on the job, through programs of career development courses and practical training. He is tested at each level and if he satisfies his training requirement, he is awarded his 5 or 7 level proficiency code.

Naturally, in this system of training, the hours spent within the framework of the formal courses conducted in our school are tangible--they can be counted. Turner's Guide to Evaluation of Educational Experiences in the Armed Services even recommends specific college credits for these in-house courses. But there has been no credit established for that learning which has taken place on the job. Many of you have worked with former military medics and I'm sure you would agree that they are capable and dedicated men and women.

If we want to keep former military medical personnel in health related careers, we have to find the way to place a value on that on-the-job learning. Equivalency examinations are the answer, but while our experience thus far indicates that many neighboring colleges and universities endorse the idea, few are ready with the necessary examinations. We did win a rather large victory, we believe, when we submitted a challenge concept to the Texas Board of Vocational Nursing. Our proposal was accepted July 26, 1971, and is as follows:

> "Our proposal is based on the rationale that students who enter the present Phase I of our LVN program have a mean experience rate of five years. They are well skilled already in basic nursing procedures and many in advanced procedures. These students have been pre- and post-course tested with the National League for Nursing Practical Nurse Achievement examinations (done by special arrangements with NLN) and the results predict that many could pass successfully the state board examination. The following policies would guide the challenge of our program:
>
> a. Challenger must be a graduate of the Phase I of the AZR90270-2 VN course. This comprises 13 weeks of didactics. An academic score of 70% in each segment of the course is mandatory.
>
> b. Student experience record must show evidence of experience in the following areas:

Medical nursing	3 months
Surgical nursing	3 months
Obstetrics/Nursery	3 months
Pediatrics	3 months

> Performance must be certified as satisfactory in each of the clinical areas by the Nurse Educational Coordinator

and/or Chief, Department of Nursing.

c. Challenger must attain a composite score of 70% or higher on the USAF Vocational Nurse Course comprehensive test. Failure to meet minimum score of 70% on any segment of the examination would require enrollment in that portion of the program. Thus, the successful challenger would receive the equivalent of a 12-month program in Vocational Nursing through testing and credit for past nursing experience."

At the Air Force School of Health Care Sciences, we will continue to explore every possible avenue to gain accreditation of our courses in the health sciences. We salute you for your endeavors to bring the need for equivalency credit into popular focus.

EQUIVALENCY TESTING AT THE COMMUNITY COLLEGE OF BALTIMORE

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EQUIVALENCY TESTING AT THE COMMUNITY COLLEGE OF BALTIMORE

Lois C. Carleton, Ph.D.

The Community College of Baltimore has long supported the concept of credit by examination. It has done this in recognition of the fact that the important question is not how a person has acquired his education, but what education he has. The policy of absolving a course by examination had been in existence at the College for many years in a number of departments.

In early 1969 a concept, new to the College, concerning class attendance and credit was proposed. The idea of credit by examination at the CCB was deliberated at length and received the endorsement of the Administrative Council, the Senate Executive Committee (faculty representation) and the Student Government Association. In September 1969, the Board of Trustees enacted the credit by examination policy, an action totally in keeping with the trend in major four-year colleges and universities throughout the country.

Under this policy, up to 15 semester hours of credit in general education subjects through College Level Entrance Program exams or departmentally constructed exams could be obtained, and in addition, up to 15 semester hours in specialized courses which by label or content are identified with specific occupational curricula, could also be granted to those who successfully passed departmental examinations. There are no prerequisites for credit by examination, but a person seeking a degree must be a matriculated student at the College.

While the College has enthusiastically endorsed and supported both the principle and the practice of credit by examination, the implementation of the policy in the various allied health programs has proved to be much more difficult and often questionable. The Nursing Department, with the approval of the Board of Directors of the National League for Nursing, is currently offering NUR 101, Fundamentals of Nursing, a six credit course, to Licensed Practical Nurses for credit by examination. The exam is departmentally constructed. Prepared guidelines, sample questions and bibliographies are made available to the applicant. Since the initial attempt was not too successful, the test is being re-evaluated to include essential core components with levels of expectation that are more realistic, and which, at the same time, preserve the integrity of the course. The crux of the problem, as the nursing faculty sees it, is how to more effectively evaluate clinical performance and prior knowledge. With improved testing devices, it is anticipated that not only LPN's but corpsmen and others with comparable qualifications can be offered NUR 101 credit by examination.

As a further step toward recognizing experience gained in other than the formal College setting, the Nursing Department is now preparing pre-tests of selected units of various courses. Those who demonstrate proficiency in a particular unit or module are exempted from that portion of the course.

In addition to the immediate credit by examination approach, the nursing faculty is continuing to explore methods of contributing to the upward mobility of those in the nursing profession. Among the plans are:

1. Selected candidates from the LPN program at Baltimore City Hospitals will have an opportunity to take the first year of the College's Nursing Program, followed by a summer work session at the hospital to meet requirements for LPN licensure. Should they wish to continue, these students may return to the College for

the second year of the Nursing Program leading to the AA degree and, upon completion, be qualified to sit for the RN examination.

2. An investigation is now underway to determine the feasibility of a nursing program which includes selected 11th and 12th grade high school nursing students. These students will be taking the first year of the College Nursing Program during their 12th year or high school, and if successful, can enter the second year of the RN program. Essentially, these students would be saving one year of time in this program.

3. Other:

    a. Deceleration of program from full-time to part-time requirements.

    b. Developmental studies to overcome background deficiencies of student.

4. Opportunity to make up program deficiencies required by the Board of Nursing Examiners.

Those who are enrolled in evening courses at the College have a further difficulty, especially with respect to the clinical portion of an allied health program. Our Medical Record Technology Program has a number of students who are employed, and, therefore, are unable to participate in clinical experiences with the group. Since many of these are actually employed in medical record libraries, arrangements have been made for such persons to be fully and critically evaluated by their supervisors. Credit by evaluation can thus be obtained for each of the three practicums. This has been approved by the American Medical Record Association, as well as by the College.

A related but unsolved problem is how to provide clinical experience for the evening students who are not so employed. Quite naturally, this pervades all of the areas of allied health since practically all involve clinical experience which is, for the most part, only available during the day hours--and this because of the normal hospital routine. The College plans to explore the availability of weekend or evening clinical hours in chronic or extended care facilities, as well as in hospitals.

EQUIVALENCY TESTING AND ESSEX COMMUNITY COLLEGE

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EQUIVALENCY TESTING AND ESSEX COMMUNITY COLLEGE

G. Norman Dreisch

First let me thank John Bacon, Joe Marschner and the Hospital Education and Research Foundation for inviting the Essex Community College to participate in this Seminar.

The College was joined two years ago by the first phase of the new Franklin Square Hospital. It is now anticipated that in another two years, extensive new building to be completed by the College and Hospital will be complemented by the addition of the new center for the Baltimore County Health Department with many of their related clinics. Beyond that, an extended care facility and a multi-million dollar medical office building are expected to share sites adjacent to the College campus. This health and education complex is unique for community colleges and has given us the impetus to develop and continue developing many curricula with an allied health flavor.

At the present time the College offers two-year curricula leading to an Associate in Arts degree in Mental Health, Medical Laboratory Technology, Nursing and Radiologic Technology. In broadly related areas the College also offers a Speech and Special Education option in the Early Childhood Development Curriculum, a curriculum in Hospital Management, a Medical Secretary option in the Secretarial Science Curriculum and the first two years of a program in Speech and Hearing Science.

The immediate future holds even more promise. Just recently, the College submitted to the State Board for Community Colleges a proposal to train Nuclear Medicine Technicians. We anticipate approval to begin the program next September. We are also rapidly approaching the completion of proposals to train Physician's Assistants and Dental Assistants.

And, we anticipate adding a Drug Abuse Counsellor option to the already existing Mental Health Program.

Beyond that, College personnel are now heavily engaged in the initial or mid-development stages in the following areas:

Physical Therapy Assistant
Gerontological Assistant
Laboratory Animal Technician
Environmental Science Technician
Food Science Technician

and, a Medical Photography option to a more general Photography Curriculum.

Almost all of these aforementioned two-year degree curriculums will be joint efforts of the members of the Health Education Complex.

In addition to these ambitious curricular patterns now being established, the College and the Hospital are currently developing a cardiac rehabilitation clinic, utilizing the facilities of both institutions, expecially those of the newly completed Physical Education Building on the Campus. The program will probably become operative in late 1972 or early 1973.

Currently the Hospital and College are also sponsoring two mini-courses for volunteers in the Emergency Room and Pediatrics Ward of the Hospital.

In four months the College will undertake a program new to the Baltimore Metropolitan Area. The new Children's Physical Developmental Clinic will specialize in improving the physical fitness and/or coordination of physically and mentally under-developed children. It will be similar to clinics run in Prince George's College and at the University of Maryland.

Late last spring, the concept of credit by examination was approved by the President of the College. Credit by examination at Essex is designed to serve the student who by past work experience, self study, and/or travel experience has mastered subject matter generally equivalent in scope to courses offered at the College. Up to one-half the number of credits a student is required to take on campus toward the Associate in Arts degree may be earned through credit by examination. For example, our normal Associate in Arts Program requires 62 credits for graduation. A student who transfers to Essex with 20 credits already earned at an accredited institution would then be allowed to challenge by examination as many as 21 of the remaining 42 credits. A student with no previous transfer record would be allowed to challenge 31 credits--roughly 10 courses--by examination.

In order to provide the student with more than one alternative, the College does not limit the use of this medium to any special program such as the College Level Examination Program (CLEP) or the Advanced Placement Examination Program, although these examinations are applicable in many instances. Academic Divisions within the College vary in their use of testing instruments and general policy on credit by examination. It is, therefore, incumbent upon the student to ascertain the requirements of the Division in which he would seek credit by examination.

It must be noted that credit by examination granted by our College does not insure the transferability of that credit to another college, whether it be a two-year or a four-year institution. A student is advised to explore the requirements of the college or university to which he plans to transfer and college counselors are available to assist in this exploration.

The following guidelines constitute collegiate policy on credit by examination: First, examination policy varies from Division to Division within the College. Credit may be awarded for satisfactory completion of written departmental examinations, of standardized national examinations, and/or of oral or performance examinations administered by a jury of faculty members. For example, an art student may well display a portfolio of his work to a jury of faculty members from the art department.

Second, up to one-half the number of credits a student is required to take on Campus toward the A.A. Degree may be earned through credit by examination.

Third, before any examination can be administered, a copy must be on file in the Academic Dean's Office and a minimum satisfactory grade established.

Fourth, no tuition will be charged for credit earned by examination. A check for $15 made payable to the College must accompany a request for an Essex Community College administered examination. Request forms are available at the College.

Fifth, students taking one of the nationally standardized equivalency examinations, CLEP for example, are responsible for having test results sent to the College's Admissions Office by the examining agency. I would recommend, however, that before any student decides to take a CLEP or other standardized examination that he check with the appropriate division or the Academic Dean's Office at the College.

In relating this specifically to the allied health curricula, you must realize that we are just beginning to implement the credit by examination policy and that clinically-oriented experience is most difficult to evaluate. The College has an immense responsibility to examine such experience thoroughly before granting their imprimatur. We have made some significant strides already and more will follow.

In general, let me say that most of the regular science, business, English, mathematics, and social sciences courses that make up peripheral support units of the allied health curricula are already challengable by examination. In addition, some mandatory core courses in the Medical Laboratory and Nursing Programs can be challenged by examination. And, examination criteria for two of the five Radiologic Technology clinically oriented courses are now being developed and should be available by early next year.

I would also like to mention that last year the College applied for federal funds to begin the study of another program that will require extensive equivalency testing. If the funds become available, the College would undertake a study of a career ladder program--upward mobility--for Nursing Assistants, LPN's and the Associate Degree nurse. Again, I maintain that such a program should be replete with equivalency testing.

In closing, I would recommend that anyone with specific questions be directed to the Academic Dean's Office of the College. We will be happy to deal with individual cases.

EQUIVALENCY AND PROFICIENCY TESTING
WHERE IS JOHNS HOPKINS HEADED?

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EQUIVALENCY AND PROFICIENCY TESTING
WHERE IS JOHNS HOPKINS' HEADED?

Harvey Webb, Jr., D.D.S., MPH

Introduction

A. Real Case Studies (Names have been changed)

Case Study 1 - Mr. Robert Winowski, 42 year old black male, high school graduate, 23 years as military corpsman. Attended medical training school; special diet course; trained troups in basic care of combat wounds; service experience includes: starting I.V. therapy, prescribing and administering medication, giving immunizations, assisting physicians in bone marrow biopsies, suturing, filling prescriptions, running routine lab tests, operating EKGs, giving eye tests, assisting in physical examinations, ordering medicine and medical supplies, independent treatment of minor illnesses, serving as health officer for evaluation of water supply and environmental problems. Wants to develop himself in a significant health career and obtain college credit.

Case Study 2 - Mrs. Barbara Jones, 34 year old white female. High school graduate, married, four children, 4 to 18 years. Work experience includes: aircraft factory mechanic, housewife, involvement in community activities, work in health field for 13 years (11 years as secretary, 2 years as unofficial administrative assistant). She was the behind-the-scene developer, program planner, coordinator, and adviser to the director of a major health clinic. Excellent at relating to people and maintaining interpersonal communications. Provides guidance and training for entire administrative staff, has good oral and written communications skills, works well in one-to-one or group situations, highly motivated. No other formal training or courses. Wants to develop in health field and obtain college credits.

It is obvious that the individuals named have backgrounds which demonstrate knowledge and skills in specific areas of allied health subject matter but are limited in their academic background and social credentials.

There are certain questions that Johns Hopkins must answer in developing its School of Health Services.

1. How does one accurately assess the knowledge, the skill and the real life experiences accumulated by these and other individuals like them?
2. On what basis will eligibility for matriculation be determined?
3. Will there be a continuing educational process and, if so, what kinds of assessment mechanism should be used initially and periodically to ascertain their current status and insure their continued development?
4. Do current evaluation techniques of equivalency and proficiency testing satisfy our requirements in light of the current health manpower needs and the goals of the Johns Hopkins Medical Institutions?

B. Goals

As currently outlined, we see our mission as:

1. The maintenance of a central focus on the student, with encouragement of individual growth, a high level of performance and competence and academic excellence in the Hopkins tradition.
2. The development of a high level of personal interaction of the new health professional with new and traditional personnel, and an interdependence of function with other highly competent health professionals.
3. The development of careers for all levels of allied health personnel.

4. Making an accurate assessment of a student's current level of knowledge, and placement of students in an environment where maximum development can occur.

5. The establishment of curricula with a high degree of flexibility to reflect appropriate scientific responses to current social demands.

6. The creation of a continuum of training to assure the delivery of high quality care and promote employee job satisfaction on a long term basis.

It is therefore our mission, like others, to develop an "open, humane, efficient and innovative institution that is future oriented, service minded," with a quest for "qualitative excellence."

What We Look For

From the student:

1. The background that he brings as he applies for career development in the health field;
2. His ability to communicate effectively.

From the school:

1. A determination of the knowledge and the skills needed in the job to be performed by the prospective worker;
2. An ability to provide that added knowledge and those skills not already possessed by the student but required to insure the future competency of the individual.

How We Propose to Obtain This Data

A. Job Task Analysis

A complete and detailed job task analysis will be needed in order to ascertain what it is we would like for the individual to know and do. This will be the keystone of our assessment process. All job tasks that are required to be performed by a worker at varying levels of his development must be broken down into their components. The institution must assay the level of knowledge and performance demanded upon completion of its course of study. As an institution, we must be positive that the tasks outlined are those actually to be performed, and we must validate our ability to measure the applicant's competence at performing these tasks. We must be able to determine the student's task performance level, his knowledge of the task at that level, and his overall proficiency in knowledge of the particular subject area he will encounter as a health careerist.

B. Background

We shall look for the candidates that have in our estimation accomplished something in life by their own merit. We shall pursue all individuals who, regardless of lousy grades, a deprived family background, and being born with the "wrong" accent, religion or color have demonstrated maximum use of their inherited resources.

A systematic appraisal of the individual's work record, i.e., time on the job, manner in which he has performed, the number and kinds of jobs held, and the nature of independent actions for achievement he has exhibited in those positions, will reveal some signs of stability and drive in work profile.

In essence, we will question what has transpired with this individual in a real life situation and how hard he has tried to accomplish a given task overtime.

C. Communications and Problem Solving

In a highly mechanized society it is essential that the student develop multiple means of communication to function in a multi-professional situation as a health career presents. The individual's ability to communicate orally and in writing will help determine his effectiveness in "coming across positively" to his co-workers and those with whom he will be closely associated. Evaluation from past history of his ability to consolidate the various means of communication, and to recognize channels of communication other than those structured, will evoke the candidate's ability to apply the best technique to appropriate situations.

An added essential for individuals who expect to advance to positions of responsibility in health careers is the capability to solve problems. We will assess how an individual handles himself in crisis situations or in projected interpersonal conflicts and confrontations. We shall anticipate as near as is possible his expected behavior under known circumstances, based on projections from past performance.

D. Knowledge and Skills to be Taught

Finally, we must determine from the information gleaned in the answering of previous questions, what knowledge and skills must be taught so that the individual may be complemented as a total human being with health career goals. Correlation of information gained from academic sources, work experiences, social interactions, and from methods used in problem solving in his personal as well as his work-a-day life, will provide a sum total of the prospective student's status. Once this has been determined we must assay to what degree and at what level reinforcement is necessary to satisfy the needs areas identified and determine at what level in the health career ladder he is prepared to fit. Careful evaluation must be made to ascertain the amount of course work necessary for him to become proficient in a given skill or to function at an acceptable level of proficiency.

How Will We Find It?

A. Academic Records Performance

Significant academic records from high school, college and other training programs in which the prospective student has previously engaged. All available test results will be included as background for analysis.

B. Standardized Test Performance

The School proposes to enroll students for the last two years of college and the College Level Examination Program (CLEP) or other standardized tests will be used in assessment of their preparation. Since CLEP's development was based on the assumption that many people know much more than their academic credentials would suggest, it is felt appropriate to get maximum use of this established examination to measure achievement in specific subject areas. The use of such widely accepted, previously validated and standardized tests will allow the School additional advantages:

1. They will provide an evaluation mechanism for comparing the entry performance level of our students with students of other schools within the Johns Hopkins Institutions, as well as with students from other colleges and universities.
2. They will give us an opportunity to measure the validity of CLEP or other standardized tests against our own operational performance standards over a period of time (say five years).

C. Job Skill Performance

In the health field, performance takes a much greater significance than in other areas. Extremely little information is available along these lines. Therefore, we propose to use the job task analysis as our baseline data and create the assessment tools necessary to evaluate the subject matter.

From the initial or entry stage we shall prepare our students to perform meaningful health related job tasks and to utilize the information gained from these experiences to score their overall proficiency. Each student will be allowed to challenge as many skills as he feels he has proficiency in and will be afforded complete academic credit where his scores indicate a high degree of knowledge and competence. The performance examinations will involve the creation of situations, hypothetical patients, and planned crises consisting of solvable and insolvable problems with graduated degrees of complexity. They will be a test of knowledge, skills, judgmental ability and human interactions applied to real life experiences anticipated in health careers.

D. Interview Performance

One of the most informative techniques for assessment of personal traits is the face to face interview. We are convinced that a well structured, guided interview can be helpful to the student who does poorly under normal testing procedures and assessment measures. Such an encounter will be informative for an institution which must train in the health field, and for the student whose ability to handle written and oral communications is essential to his career development in a multiprofessional environment. The interview will be diagnostic in its approach and analytical in its process. Educators and psychologists will be used to build on current knowledge in the development of diagnostic questions that probe the student's work history, social background, attitudes and personal motivation. These sessions will allow for the assessment of the individual's interaction and relationship with other human beings in his own peer group as well as persons in authority.

Selection

Our final student selection will be based on a composite performance score from all possible sources: academic records, standardized tests, past work experience, references from previous employers, and performance on situational and interview-encounter sessions will be compiled individually and collectively. Each of the categories will be weighted with emphasis on the individual's ability to produce under the circumstances surrounding the various assessment techniques. Those persons who demonstrate, by previous work and real-life experiences that they possess the reliability and equilibrium to accomplish a task or thought process, are motivated and committed to health as a career, and are academically capable of coping with the subject matter, will become prime candidates for consideration of acceptance into the program.

Follow Through

An integral part of the entire assessment effort must be a matrix of collaborative and cooperative learning. Initially, acceptance into the program implies a responsibility on the part of the institution as well as the students. The institution will be responsible for academic reinforcement of areas of minimal knowledge, and challenge and encouragement in areas of advanced knowledge and skill. The School must learn and provide what the students require for development. The most accelerated curriculum adaptable to the individual student will be made available to capitalize on his strong qualities and to prevent duplicate learning. On the other hand, careful counseling and enrichment shall be provided for the tutoring and support of students who need assistance. The School and the student must learn their limitations in respect to each other. Peer learning will be promoted through planned student interaction and multimedia programmed learning centers. This process will also include faculty and staff members so that they will understand the teaching and learning phenomena. The student faculty ratio, to be established at 8/1, will remain as low as is required for maximum student development.

The student knows what he knows but not what he doesn't know or what he needs. The institution, on the other hand, will validate this knowledge and skill level, credit him appropriately, and obtain insight into what is needed to aid him in achieving his aspirations. This shall be accomplished by the use of check lists, anecdotal records, and student self-reports.

Summary

We have the formidable task of preserving the health care system by developing competent people quickly. We have within our own ranks persons with untapped resources for delegation of additional responsibility. How can we convert the knowledge and skill from their life experiences into competent performance to relieve the current and future health crises? We propose to accomplish this by shouldering our full portion of the responsibility to identify the jobs we expect to have done and thoroughly analyzing their relevancy to the knowledge and skill levels we expect the student to reach.

Job task analysis is the key to our assessment process. In addition, evaluation of student performance on standard tests, in programmed diagnostic interview and problem solving solutions will be incorporated into a composite score. Based on these analyses, a curriculum will be developed which is adaptable to the individual student needs and provides the prerequisites for challenge and support to assure a high degree of career motivation and multiple opportunities for immediate and long term reward.

THE ALLIED HEALTH PROFESSIONAL AND THE HEALTH CARE INDUSTRY

Theodore P. Hipkins
President
Appalachian Regional Hospitals
Lexington, Kentucky

THE ALLIED HEALTH PROFESSIONAL AND HEALTH CARE DELIVERY

Theodore P. Hipkins

Your program director asked me to speak on three specific items: (1) the need for training more allied health professionals (from my point of view), (2) the role of equivalency and proficiency testing in speeding up the training of such employees, and (3) that if Appalachian Regional Hospitals either has in being, or in the planning stages, any significant programs that include the equivalency concept, to mention them briefly. I would like to add a fourth item here and that is the impact of the changing patterns of health care delivery on the three basic assignment items.

In addition, I would warn you that I speak to you from the base line of the manager of a multi-state, model, rural, non-profit health care system, that includes various levels of care over and above the traditional hospitals named in our title.

And, further, I would like to remind you that I view all of the above from the point of view of the manager, where management is described as the art and science of getting work done through people. In the case of Appalachian Regional Hospitals, Inc., that means in excess of 3,000 people scattered in perhaps 40 different operating entities in four different states.

Need for Training

With that introduction, let me speak first to item number one--the need for training more allied health professionals. I'd like to be sure that we understand each other when we use the term allied health care professionals. Let me use the analogy of "the volunteer professional army" where, at every level, the assumption is that the individuals involved are well trained and qualified for their particular job, and are "professionals." We are not talking solely about the professional battalion commander without also talking about the professional rifleman and the professional squad leader. If agreed, then we are on the same track, for in the business of health care, perhaps to a greater degree than anywhere else, the people at all levels play an extremely important part when they play their part. As such, the aide is a professional health care worker, the janitor in an ambulant care center--because he is part of the surroundings--is a professional health care worker, et cetera, et cetera. If we can start from that base line and not think just solely of professional nurses, and graduate physical therapists, and Ph.D. clinical psychologists, then we are on the same wave length. If you are thinking only about the upper hierarchy, then we're not.

Let's assume we are. Very well then; there's no question but what the national statistics talk to us about the great need for further allied health care professionals. A typical category is that of rehabilitation counselors. In 1969, we had 12,000. It was estimated that by 1975 we would need 25,000. Now this is the masters level counselors. I could probably cite the same kind of figures from other categories, such as physical therapists, lab technologists, social workers, medical record librarians, et cetera, et cetera. And I could agree that we have some needs in Appalachian Regional Hospitals, although not as much as you might think. I would have to say that I look with a somewhat jaundiced eye to the kinds of figures as noted above. By and large these figures tend to be compiled by the professional groups concerned, whose understandably exaggerated view of their own singular importance tends to color the picture somewhat. This is not limited to any one category. With respect to ARH's needs, we think we demonstrate one thing, with respect to scarce personnel; and that is, we have less scarcity than we used to have. We think it is because we have new exciting and interesting programs that appeal to genuine professionals, and as such, our recruitment problems are not as great as perhaps those of some of our associates who still insist on doing it the same old way.

Doing it the same old way then leads me to the next input that casts shadows of doubt on the national statistics and that is: it's no longer the same old game! We are seeing rapidly changing formats and patterns in the delivery of health care and we haven't begun to stabilize in any new ones yet. We're seeing the rise of the concept of appropriate levels of care; we're increasingly seeing that the physician and the hospital are no longer the sole providers of health care; we're seeing the development of extended care facilities, and an upsurge in the utilization of hospital-based ambulant care centers, as well as satellite ambulant care centers. We're seeing self care units and, in the other direction, more and more sophisticated intensive and coronary care units. We're seeing increased recognition in the health care delivery system of the efficacy of certain rehabilitation facility concepts. We're seeing the increased understanding of the value of, and the utilization of true team care. We're seeing greater and greater understanding of the fallacy of treating just the impairment alone; particularly as we're dealing with the problems of chronic disease. We're getting more and more adept at looking at, and taking into account, all of the obstacles that impede maximum function in an individual. In other words, we're beginning to work with the total handicap of individuals.

And finally, we're recognizing that in our health care delivery the old mental health goal of maintaining a therapeutic climate is indeed increasingly, and perhaps in some of our dealings with chronic disease, the most important single ingredient necessary.

Now if you scrutinize all of these shifting patterns then you'll find that the kinds of people (and the training) needed to staff them are perhaps not necessarily the same as in the old days. It may be, for instance, that as the levels of care that I have described to you do attain a greater ascendancy, that hospitals per se will decrease in relative importance. As other levels increase in relative importance, one consequence will be that the kind of people needed may very well need less focus on technical skills per se and more stress on, for instance, good inter-personal relations capabilities, et cetera. If this indeed is true, of course, it's going to require a thorough review of our laws, "standards and ethics," and licensure views. It's going to complicate our lives and it may have a very profound effect on the kinds of people that we are equivalency-testing and/or training for work in the health care field. I might say, as a piggy-back here, that it may be that there will be just as much a requirement for continuing education as there is for threshold training for these individuals.

Role of Equivalency and Proficiency Testing

If we are thinking of using new kinds of health care workers, or modified kinds of health care workers, and if we are concluding that some of their prior experience, no matter where, may have relevance to their new projected roles; or if they have not come up the traditional route via high school, college, graduate work, et cetera; and if we're going to use them, we must indeed find ways to recognize them and award them with a status appropriate to their new role and their prior experience. If this is the case, then equivalency and proficiency testing would assist in speeding up the training as well as the promotion of such employees or potential employees. Certainly, there's plenty evidence, as you know better than I, as to the validity of recognizing people for experiences past.

The GED concept has been a very valid one since 1946. As recently as this year, the Commission on Accreditation of Service Experiences conducted a survey to determine how widely accepted the GED test results are for college admission. 1,968 institutions of higher learning were queried; 1,721 responded. On the question, "Does the policy of your institution permit the admission of non-high school graduate adults who used GED test scores as evidence of their ability to undertake college work?" the results were extremely favorable. Of the 1,625 institutions that have established policies as defined by this question, 93.23 per cent answered yes. If this again is a valid concept, certainly it is transferable as you already know into other kinds of equivalency testing. Certainly, it would help us fill our manpower needs sooner if not at once, it would recognize the valuable experiences of people in the armed forces, people at lower level jobs of more traditional health care positions, et cetera, et cetera. It would not require that we wait for six more years to develop a first-class case worker, et cetera, et cetera, as under the old ways.

However, equivalency and proficiency testing must be a broadly interpreted process. In many instances, it must be primarily an unassembled evaluation, it must be heavily weighted with respect to attitudes and motivational factors, and less importance placed on the technical areas. If you must use assembled examinations, then perhaps the technical area does make a legitimate place to so do.

ARH Equivalency Efforts

As to significant programs that utilize the equivalency concepts in ARH, this year in our School of Professional Nursing, a three-year diploma school, 12 of our 51 admissions have been given 12 months advance placement credit on the basis of some equivalency testing measures. These are all licensed, practical nurses with certain years of experience, who are given certain other equivalency determining tests and, as a consequence, will have 12 months of what would normally be a three-year course lopped from their regime.

In our management staff, we have recently assigned an administrator at a new hospital based entirely on his performance in various roles in a health care system, and in spite of the fact that his formal training has only been one year beyond high school.

In one of our emergency rooms in one of our larger hospitals we are developing an emergency room technician type. We are in the process of replacing all of our nurses by this particular kind of worker, and his qualifications to perform in this important and responsible role are based, in part, on the performance type examinations that are conducted not only initially but periodically.

Summary

In summary, what have we said, then? Well, I have agreed there is a need for training more allied health professionals; agreed there is a role for the use of the equivalency and proficiency testing in speeding up the supply of such employees, and noted that the concept is already in use--it's not a new one. And, I have agreed as a manager that it has sufficient merit to bear proliferation, but, and however, I do so with the expectation that its focus must veer away from yesterday and today's requirements and pay more attention to things to come!! And, finally, as you develop these qualification tests in order to upgrade people, or to give them advance standing, the final planning question certainly should not be "what's in it for the professionals?" that will be created, but "what's in it for the people they'll serve?"

RECOMMENDATIONS

OF

TASK GROUPS

GROUP I

What actions should professional associations take in understanding and facilitating equivalency testing?

In the discussion of the group, it was acknowledged that equivalency testing is not a well understood concept in professional health organizations. Therefore, we believe that:

1. Vehicles must be developed for providing an understanding, and appealing for support of the concept by these organizations. We had the following reasons for making this appeal:

    a. This would provide a means to decrease the cost of health education,

    b. This would also provide a means for indirectly decreasing the cost of medical care,

    c. This would provide a means of increasing and improving the delivery of health care,

    d. This could help to provide incentives for individual achievement of health professionals, and,

    e. It could accelerate the flow of manpower into and through the various levels of competency in the health fields.

    We would like for this collective group to join our task force in making this appeal.

2. The mass media can be used more effectively in disseminating information on equivalency; and that opportunity should be provided for face-to-face confrontation and exchange throughout the deliberations leading to knowledgeable and unified action on the part of the health organizations.

3. Activity should take place at the national, regional and state levels in the preparation and administration of the equivalency vehicles. Health professions should work cooperatively with the education community which we feel is neither qualified nor motivated enough to do it alone.

4. There needs to be some type of collaboration between the two to be sure that these vested interests do in fact get together and work cooperatively on the task.

5. Task analysis is a very necessary step. Each professional organization could combine its expertise with that of the team doing the task analysis.

6. An organization such as MHERF, which has a multidisciplinary approach and base, could bring together health organizations and educational institutions in the development of equivalency testing. This would help insure that it is done and that it is done well.

7. An appeal should be made to health organizations for a system of accountability on equivalency testing, to the health professions, to educational institutions, and to consumers.

8. Analyze the very difficult task of accountability to consumers.

9. Request of the national organizations that they reexamine their current certifying examinations to insure that these examinations do in fact serve the purpose of identifying the supply of competent health manpower.

Erwin H. Pepmeier, Jr.
Moderator

GROUP II

What should be the role of licensing boards in the development and implementation of equivalency testing?

1. State licensing boards should recognize the need for equivalency testing, officially state their approval of the concept, and strongly urge schools (which they recognize as training areas for the various allied health professions) to undertake programs of equivalency testing.

The group feels that the development of the tests themselves should be largely left to the educational institutions which are accredited to train the various allied health professions; that if the school is so recognized by the licensing body or the national registry, it would then be recognized as capable of developing tests which would measure equivalency.

2. It was recommended that the state licensing boards encourage the development of private projects in various educational institutions to attempt to devise tests which produce the most accurate measure of equivalency.

3. Licensing bodies could then collect the results of the experiences of the educational institutions within their jurisdiction and disseminate this information to other organizations within their jurisdiction so that the problem of "reinventing the wheel" would be avoided. Thus, if one school has developed a rather successful technique, that information would be communicated to other schools which might also be able to use it.

4. It was recommended that there be developed a state task force composed of representatives of all the licensing bodies and the national registries who have their members practicing or working in the state.

This task force would examine the possibility of developing a single licensing agency for the state rather than having a state licensing board for nursing, a separate one for another allied health profession, and so on.

One agency should be created which would certify or license all of the allied health professions. It was thought that by using such an agency, educational programs and curricula could be developed which would provide for a great deal more lateral mobility.

It would be far easier for the LPN, for example, to progress into the registered nurse ranks if the control, licensure, and overseeing of this progression were under the jurisdiction of one body. At the present time, you have almost an isolation of each profession; it was felt that one body, once again, to recognize all allied health professions, would be a help in this area.

5. It was further suggested that the national professional organizations and the national registries make the effort to design tests also. These could be suggested tests which would serve as guidelines to the educational institutions in forming equivalency testing programs.

Francis P. Lynch
Moderator

GROUP III

What changes must colleges, high schools and other educational agencies consider and implement in support of equivalency testing?

1. That a telegram be directed to Governor Mandel urging that he suggest to the Conference on Higher Education being held on November 5, 1971, that they consider statewide approval of the concept of equivalency testing for Maryland secondary schools and institutions of higher learning.
2. That the Maryland Hospital Education and Research Foundation call for a meeting of the Maryland Health Careers Promotion Council and appropriate state education agencies for joint consideration of further implementation of equivalency testing in the allied health fields.
3. That each Maryland institution now involved with equivalency testing maintain continuous study of the equivalency testing practices under a number of alternate curricular routes to vocational proficiency. Several models should be established in the immediate future.
4. That an all-out effort be made to acquaint all people concerned with curriculum development at all levels of education to identify, where appropriate, the relevance of courses to health careers.
5. That where appropriate, members of the health professions be included on all curriculum development committees.
6. That teacher preparation institutions include in their programs information about health careers and the importance to our society of motivating students to prepare for these.
7. That at all levels of education and in professional organizations

recognition be given to relevant experience obtained outside formal education.

Moses S. Koch
Moderator

Vernon Wanty
Recorder

GROUP IV

What rights and obligations do the hospitals and other health agencies have in the development of equivalency testing?

We attacked the question from some points of view and attempted to answer what we thought were some really vital questions.

1. We think there is a real need for boards within the hospitals and within educational institutions to make some real commitment to equivalency testing. We think that commitment is vital and necessary.

2. One of the questions we dealt with was "Is equivalency understood?" and we came up with the general conception that it is not understood in its context and that something should be done in the way of education as to what equivalency really means. Are organizations needed to assist with orientation to this concept? We definitely think they are. Should questions of equivalency testing concepts and methods be placed with a high-level group including hospital board representation, health groups, and an education component participating?

3. Task analysis is a basic procedure which should involve the aforementioned health and education agencies and institutions. There should be continuing involvement of all groups concerned with training and equivalency credit.

4. In our group, the hospital representatives said to the educators: "You train who you want; we are only going to accept what we want." On the other hand, the representatives from education said: "Unless you tell us what you want us to train for, we are going to be turning out whatever we think you need." There is a great need for the two to get

together. It was pointed out that unless there is this type of involvement and some pressure from the hospitals upon the educational institutions to produce the necessary health care workers, they will both go along in the present pattern of producing what each thinks is necessary.

5. There was a recommendation that people stop "talking" and start "doing." A question arose which we could not answer: "How committed is this group, or the hospital, or education, to equivalency testing?" We believe there is a real need for this combined group to start working on some commitment to equivalency testing.

Frank R. Gabor
Moderator

Gilbert Hankes
Recorder

GROUP V

How will legal problems be surmounted relative to professional competency and qualifications?

Although our topic was specifically geared to professions that are not under existing statutes, our group could not realistically divorce itself from a consideration of present licensing situations, what they provide, and what restrictions they impose.

1. We would first like to echo the call for a two-year moratorium on licensure of additional categories of allied health professionals. It was also hoped that after the moratorium expired there would be a curtailment of additional licensing and a greater emphasis placed on the flexible and responsible utilization of manpower by institutions and health professionals.

2. We want to assure recognition of the knowledge, power, and needs of consumers of health services. With the advent of general health coverage, there will be an increasing need to keep the public aware of health programs and how new categories of health manpower are developed and utilized. We must have well planned and well implemented public information programs and provide for extensive use of consumers on licensing and accrediting bodies. (This would allow the public to know how they are being protected from incompetent or unethical practitioners.)

3. We need a concentrated, cooperative effort by those involved with the training, utilization and credentialing of health manpower to determine where equivalency provisions can be employed. Evaluative tools should be developed that will measure the individual's achievement of specified objectives in both theory and practice in a given course or

program of study. This measurement should reflect achievement comparable to that of other individuals who have successfully completed the academic course.

4. Continuing evaluation should be required of established standards in licensure to assure their relevance and flexibility to meet current needs in the delivery of health services.

5. The authority of licensed individuals should be broadened to enable them to delegate duties to qualified personnel under their direction, whether they are credentialed or not.

6. Valid evaluative requirements and periodic recertification of health personnel should be established to assure continued competency.

Harry Wesley Whiten
Moderator

GROUP VI

How will problems in test design best be overcome?

We want to first call your attention to the definition that we were given to begin with. Repeatedly, we came back to the fact that we were talking about equivalency examinations that might be designed to enable colleges and universities to grant academic credit for off-campus learning, and also, proficiency examinations that might be used by employers or certifying bodies to qualify individuals whose non-formal study and on-the-job learning is equivalent to that expected from a formal program.

Our committee believes that equivalency testing should exist, and that it ought to be done by more than just single institutions in order that it have more credibility and transferability.

1. We hope that CLEP will continue to design more tests in the health fields. We did not go into the technicalities of validating the exams because we thought that the pattern established by the CLEP program would be the natural one to follow.

2. We felt that Maryland institutions and organizations together could spearhead a pilot project in equivalency testing which would be useful nationally. We thought that such a project could, in addition to colleges, represent employers, state and local government, unions, armed forces, and we would expect it to receive guidance from CLEP as well. Such a pilot project could encompass a testing and counseling service and could be set up with batteries of aptitude testing for students. Both written and performance examinations would be useful in identifying the problems in developing examinations. Perhaps general guidelines could

be established which local institutions or organizations could follow in assessing performance.

3. Task analysis is essential, based not only on present manpower utilization, but on emerging health care needs which will unquestionably necessitate new approaches and professions in the delivery of health care. Accordingly, we hope that a continuing review system can be built in.

4. The question of funding arose and while no quick, easy answers were found, it was agreed that the public need is great and this might lead to outside funding.

Jean D. Linehan
Moderator

GROUP VII

How can we best translate military experience into professional skills and knowledge?

We began by saying there is a major issue overriding that of equivalency testing: There are competent people leaving the military forces who are able to do a number of different things today and are not able to enter into the system because of employment requirements, professional standards and so forth. Aside from the subject of equivalency testing, the group addressed itself to the question of determinants of competency to do a job.

To do an increasingly complex and quite new job in a number of areas of community health service, it looks like a guy who has been an independent solo practitioner in the armed forces with a lot of training and experience ought to be employable directly, without having to translate his experience into educational equivalency. Brief examples of this: A highly qualified clinical instructor from the armed services is today employed as a security guard. He is told he is not qualified for any clinical positions within our educational system in the state. Similarly, in a community college represented in this conference, a highly qualified clinical individual from the armed services, discharged recently, is directing a program in allied health education. He is employed at the lowest level on the educational totem pole as assistant instructor because, again, he does not have academic qualifications that meet the test we traditionally apply to educators within the particular system.

While we need to work hard on all areas of this problem -- equivalency testing being one of the major areas -- the utilization of competent personnel is something we need to be concerned about on a systems basis; not alone on an educational basis, and not alone on a hospital or health industry basis. This is a major systems problem. We need to find a different way to get together on it, as we are really delivering rather poor service in many respects and we are not using people who are highly competent to provide the kind of service needed within communities today. Our group began from this point.

In equivalency testing, specifically, our task force does make a number of recommendations.

1. The returning military person has a recognized body of training. There is available to educational institutions, the health industry, and to state organizations a complete catalogue of courses which are provided on a standardized basis throughout the armed services and those courses have been studied and analyzed by a commission of the American Council on Education. Guidelines have been developed for the direct transference of that training experience into course credits.

We recommend that the agencies responsible for higher education, and specifically the State Board for Community Colleges, be urged to review the guidelines in depth; that they report and develop guidelines for use within the educational system for transfer of military training; not to use the military training experience as a license to take another examination, but for direct transferability into academic credit.

2. Recommendations have been made by many of the other groups here relating to various licensing, certifying, and other professional bodies in our allied health fields. Great strides have been taken if you look at some of the progress that has been made in these fields. Our task

force says again that, at least in terms of the military experience, it ought to be possible within the regulating bodies to give specific credit based on direct transferability without the necessity of another intervening examination. We urge that the licensing boards and certifying bodies address themselves to this question.

3. There needs to be coupled with this direct transferability some direction in clinical testing of individuals entering the health professions. There are innovative ways of doing this and, in some of the community college programs today, in some of the schools of practical nursing, and many other bodies, it is already taking place. We urge all licensing boards to look at the curriculum, the course content, and the courses offered throughout the armed services to evaluate in terms of transferability, and that this be coupled with practical clinical examination to determine the clinical competence of individuals entering into a given level of the allied health field.

4. This recommendation is directed to the MEDIHC Program, organized under the Maryland Hospital Education and Research Foundation and funded by a grant from the State Department of Health and Mental Hygiene. The MEDIHC Program's accumulated data, including various manuals, catalogues, and other materials, ought to be made available to admissions officers in the community colleges and other levels of higher education, hospital and health organizations, and each of us in the business of health education. We think the MEDIHC Program has a vital role in that connection and urge continued and expanded support to insure that this piece of business gets done.

5. Our final recommendation is that action is required NOW. While we make recommendations to a variety of official, governmental and private

bodies, we believe that the job can begin where each of us is today. The job can begin in terms of the guy who is now employed as a security guard; it can begin with the community college which is employing a qualified clinical person as an assistant instructor. It can begin with each of us who has a responsibility for admitting people into the educational programs in the health fields. It rests with each of us individually to help accomplish the goals of this meeting.

Joseph Murray
Moderator

APPENDIX

a. Seminar Program

b. Seminar Faculty

c. Participant Roster

d. Telegram to Governor Marvin Mandel, State of Maryland, and Reply

e. Glossary

f. Selected References

g. 1971 Status of Maryland Community Colleges Regarding Credit by Exam, Challenge Courses, and External Degree Programs

SEMINAR PROGRAM

Tuesday, October 19th

9:00 a.m.	Registration and Coffee
10:00 a.m.	Call to order: John F. Bacon Greetings: Sherburne B. Walker
10:10 a.m.	Keynote Address: "Opening Doors to Health Careers" Dr. J. Warren Perry
10:45 a.m.	Panel Discussion: "National Trends in Allied Health Testing" Moderator: Richard J. Davidson Panelists: Dr. James E. Griffin Dr. Israel Light Albert M. Serling Mary A. Goddard, R.N., Colonel, U.S.A.F.
11:45 a.m.	Questions and Answers
12:30 p.m.	Luncheon
1:30 p.m.	Panel Discussion: "Innovative Approaches to Allied Health Equivalency Testing in Maryland" Moderator: Alton E. Pickert Panelists: Dr. Lois C. Carleton G. Norman Dreisch Dr. Harvey Webb, Jr.
2:15 p.m.	Questions and Answers

2:45 p.m. Task Force Activities

4:45 p.m. Concluding Remarks and Instructions:
Joseph A. Marschner

6:00 p.m. Reception

7:00 p.m. Dinner
Presiding:
John A. Schaffer

Speaker:
Theodore P. Hipkins
"The Allied Health Professional and Health Care Delivery"

9:00 p.m. Feedback Sessions

Wednesday, October 20th

8:00 a.m. Breakfast

9:00 a.m. Call to Order
Joseph A. Marschner

9:10 a.m. Task Force Activities

10:30 a.m. Summary Panel:
"Recommendations for Action"

Moderator:
Joseph A. Marschner

Panelists:
Task Force Moderators

11:45 a.m. Adjournment

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TELEGRAM

TO: GOVERNOR MARVIN MANDEL, ANNAPOLIS, MARYLAND

FROM: JOHN F. BACON, EXECUTIVE DIRECTOR, MARYLAND HOSPITAL EDUCATION & RESEARCH FOUNDATION, INC., 1301 YORK ROAD, LUTHERVILLE, MARYLAND 21093

DATE: OCTOBER 22, 1971

TIME: 12:00 NOON

THE MARYLAND HOSPITAL EDUCATION AND RESEARCH FOUNDATION HAS JUST CONDUCTED A TWO-DAY CONFERENCE SPONSORED BY THE U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE ON THE SUBJECT "EQUIVALENCY TESTING IN THE ALLIED HEALTH FIELD." PARTICIPANTS INCLUDED REPRESENTATIVES FROM ALL LEVELS OF PUBLIC AND PRIVATE EDUCATIONAL INSTITUTIONS IN THE STATE, HEALTH PROFESSIONAL ASSOCIATIONS AND PUBLIC AND PRIVATE AGENCIES CONCERNED WITH HEALTH MANPOWER. ONE OF THE RECOMMENDATIONS MADE BY THE CONFERENCE REQUESTED THE FOUNDATION TO URGE YOUR SUPPORT AT THE NOVEMBER 5TH CONFERENCE OF HIGHER EDUCATION FOR STATEWIDE APPROVAL OF THE CONCEPT OF EQUIVALENCY TESTING FOR MARYLAND SECONDARY SCHOOLS AND INSTITUTIONS OF HIGHER LEARNING.

Telegram cleared with President of the MHERF Board, Dr. Lewis Fibel, on October 22, 1971, at 11:30 a.m.

STATE OF MARYLAND
EXECUTIVE DEPARTMENT
ANNAPOLIS, MARYLAND 21404

MARVIN MANDEL
GOVERNOR

November 1, 1971

Mr. John F. Bacon
Executive Director
Maryland Hospital Education
and Research Foundation, Inc.
1301 York Road
Lutherville, Maryland 21093

Dear Mr. Bacon:

Governor Mandel received your telegram relative to his appearance at the Higher Education Conference to be held on November 5, and he has asked that I reply in his behalf.

I am sure your organization is making a significant contribution to the public health needs of the citizens of Maryland. However, the information contained in your telegram is not sufficient to enable the Governor to prepare detailed comments for his speech on November 5.

He has asked me to request further details from your office so that he may be informed of this program.

Sincerely,

Fred H. Spigler, Jr.

Fred H. Spigler, Jr.
Administrative Officer
for Education

FHS,Jr:mce

GLOSSARY*

Accreditation is the process by which an agency or an organization evaluates and recognizes a program of study or an institution as meeting certain predetermined qualifications or standards. Accreditation shall apply only to institutions and programs.

Certification is the process by which a non-governmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.

Challenge examination is equivalency testing which leads to academic credit or advanced standing in lieu of course enrollment by candidate.

Credentialing is the recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, professional association membership, or the award of a degree in the field.

Equivalency testing is the comprehensive evaluation of knowledge acquired through alternate learning experience as a substitute for established educational requirements.

Licensure is the process by which an agency of government grants permission to persons meeting predetermined qualifications to engage in a given occupation and/or to use a particular title, or grants permission to institutions to perform specified functions.

Proficiency testing assesses technical knowledge and skills related to the performance requirements of a specific job; such knowledge and skills may have been acquired through formal or informal means.

Qualifying examination is a criterion for measuring an individual's ability to meet a predetermined standard.

Registration is the process by which qualified individuals are listed on an official roster maintained by a governmental or non-governmental agency.

Terminology for health occupations is confusing unless the job title may be expressed according to the most generally accepted appropriate requirement for basic occupational preparation. An attempt to standardize terminology is:

"Technologist" "Therapist"	educational preparation at the baccalaureate level or above
"Technician" "Assistant"	educational preparation at the associate degree level (2 years of college education or other formal preparation beyond high school)
"Aide"	specialized training of less than 2 years duration beyond high school, or on-the-job training.

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*Prepared by Division of Allied Health Manpower, Bureau of Health Manpower Education, National Institutes of Health

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* Single free copy available by request to:

Division of Allied Health Manpower
Bureau of Health Manpower Education
National Institutes of Health
Bethesda, Maryland 20014

MARYLAND STATE BOARD FOR COMMUNITY COLLEGES

2200 Somerville Road, Parole Office Center, Annapolis, Maryland 21401

1971 Maryland Community Colleges
Current Status Regarding Credit by Exam, Challenge Courses, and External Degree Programs

Community College	Credit by Exam	Challenge Courses	External Degree
Allegany	None-Maryland U. will not accept credit allowed in programs like CLEP	None anticipated	None anticipated
Anne Arundel	Maximum of 30 hrs. credit may be earned in CLEP Program	Yes, Dept. administers exams not covered by CLEP	None
C.C. Baltimore	15 hrs. allowed in CLEP. 15 additional hrs. credit allowed in Dept. exams.	Yes, Dept. administers exams not covered by CLEP	None
Catonsville	Dept. administers exams in several transfer areas. Course titles available from College. All career curricula offer credit by exam. CLEP tests not currently used	Yes, through Dept. developed exams	None
Cecil	Credit by Exam allowed for any course offered at the College. $10 fee.	Yes, through Dept. developed exams.	None
Charles	Maximum of 6 hrs. allowed in CLEP Exams. Dept. Exams offered if requested by student.	Yes, through Dept. developed exams .	None
Chesapeake	CLEP program - not heavily utilized	Yes	None
Dundalk	CLEP or College developed exam, max. of 30 credits may be earned by exam	Yes	None

Community College	Credit by Exam	Challenge Courses	External Degree
Essex	30 credits may be earned through CLEP or Dept. devised exams	Yes, through CLEP & Dept. developed exams	None
Frederick	Credit may be earned in career programs only. Dept. develops exams.	Yes, in career programs only	None
Garrett	ACLT exams offered. Dept. exams administered in shorthand and typing	Yes, shorthand and typing	None
Hagerstown	Policy presently being decided by a committee established for this purpose. Currently no credit by exam allowed.	None	None
Harford	CLEP examinations used frequently	Yes	None
Howard	CLEP and Dept. exams are offered	Yes, through Dept. developed exams	None
Montgomery Rockville and Takoma Park	1969 Board of Trustee decision proposed that Takoma Park develop exploratory programs with innovative ideas for awarding credit. At this time, the Rockville and Takoma Park Campuses do not offer Credit by Exam Programs, Challenge Courses, or External Degree Programs.		
Prince George's	None	None	None

8/2/71